not prosecutable, hard to test for, like the high, often overlooked as a drug)?

✓Does your program allow for adequate detoxification? Depending on type of product abused and length of abuse, detoxification from the acute effects of solvents and gases may last for two to six weeks. During this time, the program may need to make adjustments.

✓Do you thoroughly assess for cognitive functioning, neurological damage, and physical effects? Levels of physical and cognitive dysfunction vary greatly, but some people who abuse inhalants show high levels of deterioration. Physical damage needs to be assessed early, but cognitive and neurological evaluations are often postponed until after detoxification. In some treatment populations, a high percentage of people who abuse inhalants have experienced physical and sexual abuse.

✓Does treatment include specific inhalant-focused components? Do you provide inhalant abuse prevention education? Many people in treatment are not aware of the toxicity and lethality of inhalants; they are, after all, poisons, pollutants, and fire hazards. Do you address life-skills issues? Some people start abusing inhalants as early as elementary school; along with the neurological damage, early abuse can result in poorly developed life and academic skills. Do you take into account cognitive deficits by using brief (20-minute) and concrete intervention?

✓Does family involvement include attending education sessions about inhalants, removing inhalants from the home, and providing extra support and supervision thatclients may need? Treatment programs need to thoroughly assess the stability, structure, and dynamics of the family. If family support is limited, programs should consider alternatives such as foster care.

✓Are inhalants accessible in your treatment program? Do you have a policy to secure dry erase markers, nail polish and remover, correction fluid, solvent-based glues, and aerosol products (such as deodorants, hair spray, shaving cream, cleaning products, and canned whipped cream) in your program?

✓Are staff members knowledgeable about inhalant abuse? Do they have realistic expectations for recovery? To effectively treat inhalant abuse, counselors need to understand the unique aspects of the problem, including the slow rate of recovery.

✓Does your aftercare planning take into account the specialproblems of inhalant abuse? These include easy availability of inhalants, residual cognitive impairment, andpoor social functioning. Has a school-based advocate or counselor been included in the plan?

SOURCE: Jumper-Thurman and Beauvais 1992; Jumper-Thurman et al. 1995; Texas Commission on Alcohol and *Drug Abuse*, 1997.

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COCAINE TREATMENT REDUCES HIV RISK

If Treatment Includes HIV-Reduction Counseling

Cocaine addiction has previously been linked to an increased risk of contracting HIV, mainly as a result of sharing contaminated injection equipment, unprotected sex, exchange of sex for drugs, increased sexual drive from the stimulatory effects of cocaine, and impaired judgment.

Although research has indicated that patients receiving treatment for heroin addiction have a decreased risk of HIV infection, few studies have focused on changes in HIV risk following treatment for cocaine addiction.

Now, National Institute on Drug Abuse (NIDA)-funded researchers have found more evidence that participation in cocaine treatment may reduce the risk of HIV infection.

The researchers evaluated HIV risk among 487 cocaine-dependent patients that were recruited from five treatment programs participating in the NIDA Cocaine Collaborative Treatment Study.

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